ABSTRACT

The Nevada Department of Health and Human Services (DHHS) promotes health and well-being through the delivery or facilitation of a multitude of essential services. Governor Sandoval introduced Priorities and Performance Based Budgeting (PPBB) as a process of identifying and prioritizing the State's core functions, their costs, and delivering effective and efficient outcomes. Nevada's health priorities include: 1) access to affordable and high quality health care; 2) prevention strategies that increase awareness; 3) wellness initiatives that educate, encourage and empower; 4) chronic disease; 5) quality of health services; 6) improving pre-natal care; and 7) providing accessible and affordable mental health services.

The Nevada Division of Health Care Financing and Policy (DHCFP) is pursuing the State Innovations Model (SIM) to design a statewide plan for improving population health. DHCFP will seek broad statewide support from health care providers, public health officials, industry associations, consumer advocacy groups and others to address population health issues such as behavioral health, tobacco use, obesity, and diabetes. Nevada's plan will integrate strategies based on Governor Sandoval's core health care priorities such as child wellness and prevention priorities. Nevada's SIM priorities are categorized into three innovation and systematic improvement areas including payer-collaboration, health care workforce, and Quality Improvement Assessment.

Nevada will establish baseline measures for population conditions such as tobacco, obesity, and diabetes. Ongoing assessment activities will capitalize on rapid cycle opportunities. Potential target populations include Medicaid, Children's Health Insurance Program, Indian Health Services, Public Employees Benefit Plan, and the Culinary Union's Self-Funded Plan, comprising 700,781 beneficiaries or approximately 25 percent of the State's population.

Nevada's SIM goals align with other CMS initiatives and will consider a full range of regulatory, policy, and rule making authority to accelerate meaningful delivery system transformation that maximizes the benefits of health information technology such as telehealth. We are committed to continued use and refinement of models after the cooperative agreement period. DHCFP has received broad and overwhelming stakeholder support for participation.

Utilizing nationally recognized measures that align with other CMS programs is an essential objective. DHCFP will contribute quantifiable measures with an assessment of whether the intervention can achieve CMS' TripleAIMs. Universal measures will be a function of the State's entire population. Focus areas include tobacco use, primary care, health care spending per capita, and inpatient hospital costs.

The Division's effective communication and coordination strategy will be further supported by a Quality Registry for tracking Nevada's quality initiatives. Nevada's SIM will not duplicate activities, or supplant current funding and will complement other state and federal initiatives. Once developed and fully implemented, this initiative intends to impact 500,000 Nevadans with a cost reduction of approximately $21.8 Million. The Total Funding Request is $2,550,314 with $150,000 of In-Kind Support. DHCFP will work in collaboration with Stakeholders across the state, working closely with CMS to identify innovative solutions that transform health care delivery, improve quality and efficiency, and reduce costs.

I. PROJECT NARRATIVE

Part 1. Plan for Improving Population Health

The Nevada Department of Health and Human Services (DHHS) promotes the health and well-being of its residents through the delivery or facilitation of a multitude of essential services to ensure families are strengthened, public health is protected, and individuals achieve their highest level of self-sufficiency.

To address Nevada's health care concerns, Governor Sandoval introduced Priorities and Performance Based Budgeting (PPBB), which is the process of identifying and prioritizing the Governor's vision as it relates to the state's core functions, their costs and delivering effective and efficient outcomes. This includes improved transparency to decision makers and the public; improved methods of measuring what the state does and whether agencies are making a difference; linking activities of government to achievement of objectives; and providing a platform for improvement in funding and budgeting decisions. Nevada has identified seven objectives for health priorities including: 1) access to affordable and high quality health care; 2) prevention strategies that increase awareness; 3) wellness initiatives that educate, encourage and empower; 4) chronic disease; 5) quality of health services; 6) improving pre-natal care; and 7) providing accessible and affordable mental health services.

The Nevada Division of Health Care Financing and Policy (DHCFP) is pursuing the State Innovations Model grant to design a statewide plan to improve the population health in Nevada. To accomplish this objective, DHCFP will leverage broad statewide support from health care providers, public health officials, industry associations, consumer advocacy groups, medical centers and researchers and all stakeholders to design and develop an innovation model that

reflects the unique characteristics of Nevada's health care environment and population. Nevada will collaborate with Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) in developing our strategy. Nevada's plan will address the core measures identified in the population health metrics (i.e., tobacco use, obesity, and diabetes) as well as a selection of Nevada measures based on goals that are specific, measurable, achievable and realistic. Nevada's plan will integrate strategies that address Governor Sandoval's core health care priorities as well as child wellness and prevention priorities such as reducing childhood obesity, preventing early childhood dental caries, and maternal depression to foster healthy child development. These priorities will be categorized into three innovation and systematic improvement areas including payer-collaboration, health care workforce, and Quality Improvement Assessment (QIA).

The State of Nevada's Legislative Health Committee fully supports DHCFP's application for innovation and systematic improvement in these areas. Through a cooperative effort by both the executive and legislative branches of government, Nevada will have an unprecedented opportunity to engage stakeholders at all levels.

To develop the State's plan, Nevada will establish a baseline of the current health environment based on the mortality and morbidity rates and the full extent of data reported across the state for the target conditions, including tobacco, obesity, and diabetes, among others.

The proposed interventions will align with the goals and objectives, be measurable, realistic, and obtainable in the time period provided. Throughout this process, stakeholders will be involved as they are an integral part of the success of the plan. The plan will include the evaluation and monitoring activities during design, implementation, and maintenance phases. Nevada will evaluate the initiative including a description of the methodologies, lessons learned,

and findings and recommendations. It is anticipated that this will be completed at various intervals to capitalize on rapid cycle learning and evaluation opportunities.

Population Health Metrics

Nevada is the 7th largest state by area, the 35th most populous state, and the 9th least densely populated state. For reference, the states of Massachusetts, Rhode Island, New Jersey, Vermont, New Hampshire, Connecticut and Delaware all fit within the geographic boundaries of Nevada. The current population of Nevada is approximately 2.8 million out of 316.1 million (0.9%) in the United States. Nearly three quarters of the population lives in Clark County, this includes the Las Vegas metropolitan area and the State's three largest incorporated cities. Nevada experienced a 3.3 percent increase in populations from 2010 to 2013, versus a 2.4 percent increase nationwide.

The 2013 U.S. Department of Health and Human Services poverty guideline for one person at 100 percent of poverty is $11,490 per year, and $23,550 for a family of four *(Federal Register, 78 FR 5182, January 24, 2013).* In 2012, the share of Nevada's total population living in poverty aligns with the U.S. average of 16 percent, ranking it 32nd *(U.S. Census, American Community Survey).* The share of Nevada's children living in poverty (below 100 percent) is now worse than the national average at 24 percent versus a national average of 23 percent, ranking Nevada 34th *(U.S. Census, American Community Survey).*

The CDC, Behavioral Risk Factor Surveillance System (BRFSS), notes Nevada ranks 34th in percentage of adults who are current smokers at 23 percent versus a national average of 21 percent. In 2009, approximately ten percent of Nevadans participated in illicit drug use compared to eight percent nationwide, ranking Nevada 41st, according to the Substance Abuse and Mental Health Services Administration (SAMHSA).

Per the BRFSS, Nevada has: the lowest number of adults aged 65+ who have had a flu shot; ranks 48th for percent of women aged 18+ who have had a pap smear test within the past three years; and is ranked 39th for percent of adults who have had their blood cholesterol checked within the last five years and 49th in colorectal cancer screening.

Heart disease was the leading cause of death in the state during the period 2000-2008. Nevada is ranked 43rd in the nation for hospital readmission rates. Chronic diseases such as heart disease, stroke, cancer and diabetes are among the most prevalent and costly health problems. The following table shows how Nevada compares to the national average for high prevalence conditions:

Disease/Medical Condition	Nevada	National Average
Cardiovascular Diseases	5.3%	3.2%
Coronary Heart Disease	4.6%	4.8%
Stroke	2.6%	2.7%
Diabetes	8.0%	12.1%
Smoking	22.2%	19.0%

Part 2. Health Care Delivery System Transformation Plan

Nevada is a sparsely populated state with 17 counties, but only two major population centers: Las Vegas (Clark County) in the southern part of the state, and the Reno/Sparks area (Washoe County) in the northern part of the state. Rural populations in need of an urban tertiary facility experience "access to care" problems, with distances as far as 60 miles to 245 miles one way. From the Bureau of Labor Statistics, State Occupational Employment Statistics Survey, May 2011, Nevada has 71,350 people employed in the delivery of health care services. While the national average of health care employment to total employment is 9.2 percent, Nevada's

percentage is only 6.4 percent, making it the lowest in the nation in 2011 per the Kaiser Family Foundation.

Based on Governor Sandoval's priorities and the State's overall health care objectives, Nevada will work with a broad range of stakeholders to transform health care delivery in the state. DHCFP has identified guiding principles for transforming health care delivery, many of which are consistent with CMS' characteristics of a transformed system. Models considered for this initiative will apply these guiding principles:

- Integrated providers and networks, including virtual and/or technology based, across the care continuum collaborate on delivering patient-focused, high quality health care.
- Payments to providers and/or service vendors are tied to value and performance that lead to better controlled costs.
- Every patient has a provider who is responsible for ensuring the patient has the services needed based on reasonable care parameters.
- Providers are evaluated on individual episodes of care and accountable for population based measures of quality, service and cost.
- Patients are engaged in their care and treatment decisions.
- Data is widely available and used to improve quality.
- Care delivery is unified to eliminate medically underserved and health care shortage areas.
- The number of specialists and available network providers is appropriate to the needs of the population.
- Providers achieve board certification and economic incentives are used to recognize high performance and results.

- Data is used as a basis of management and performance.
- Technology is used to minimize administrative burden and reduce administrative costs.
- State and federal regulations and statutes will be used to promote quality, performance, and service delivery while not creating barriers and/or inefficiencies that are incongruent to these principles.

The Nevada Department of Health and Human Services (DHHS) is comprised of five divisions:

1. The Aging and Disability Services Division (ADSD) in the State of Nevada represents Nevada's elders, children and adults with disabilities or special health care needs. The Administrator is Jane Gruner.

2. The Nevada Division of Child and Family Services (DCFS), together in genuine partnership with families, communities and other governmental agencies, provides support and services to assist Nevada's children and families in reaching their full human potential. The Administrator is Amber Howell.

3. The Division of Health Care Financing and Policy (DHCFP) works in partnership with the CMS to assist in providing quality health care for eligible individuals and families with low incomes and limited resources. DHCFP administers two major federal health coverage programs: Medicaid and Children's Health Insurance Program (CHIP). The CHIP program in Nevada is known as Nevada Check Up (NCU). The Administrator is Laurie Squartsoff.

4. The Division of Welfare and Supportive Services (DWSS) provides quality, timely and temporary services enabling Nevada families, the disabled and elderly to achieve their highest levels of self-sufficiency. Programs administered are Child Care, Energy Assistance, Food (SNAP), and Financial Assistance (TANF). The DWSS

processes eligibility applications for the State's health care programs. The Administrator is Michael McMahon.

5. The Division of Public and Behavioral Health (DPBH) mission is to protect, promote and improve the physical and behavioral health of the people in Nevada. The Administrator is Richard Whitley.

Each division is committed to working across agencies with Nevada's stakeholders in conjunction with CMS to design an innovative model for successful statewide health transformation.

Part 3. Payment and/or Service Delivery Model

According to Kaiser, the largest commercial insurance carriers in the state of Nevada are United Healthcare Group, WellPoint Insurance Group and Aetna, Inc. As of 2012, approximately 593,000 Nevadans are covered by individual, small group, or large group plans. United Healthcare Group is the market leader in all commercial sectors with approximately 44 percent of the individual market, 35 percent of the small group market and 68 percent of the large group market.

Health Insurance Coverage Distribution (Kaiser Family Foundation 2011-2012)

	Nevada #	Nevada %	US #	US %
Employer Based	1,276,600	47.23%	149,464,500	48.18%
Other Private	123,900	4.58%	15,771,400	5.08%
Medicaid/CHIP/Dual Eligible*	278,700	10.31%	51,097,300	16.47%
Medicare	357,200	13.21%	41,956,500	13.53%
Other Public	41,700	1.54%	3,957,100	1.28%
Uninsured/Indian Health Service*	624,900	23.12%	47,950,700	15.46%
Total	**2,703,000**		**310,197,500**	

*As of 2014 IHS had 4,793 Medicaid recipients. As of June 2014 Nevada Medicaid and CHIP

enrollments have increased significantly to 520,836 (Medicaid) and 21,488 NCU, respectively.

DHCFP is continuing to collaborate with payer and health care systems across the state. This work effort will identify additional populations that may be addressed by this initiative. Based on an initial assessment of the potential payer system collaboration, we have identified the potential population target groups as the following: Medicaid, CHIP, Indian Health Services (IHS), Public Employees Benefit Plan (PEBP), and the Culinary Unions Self-Funded Plan. This target population includes approximately 700,781 beneficiaries, or 25 percent of the State's population. Nevada is encouraging commercial plans to participate as well and will continue toward that goal. At this time, we are not considering Medicare population participation, but we are open to reconsidering if desired by CMS.

A broad spectrum of stakeholders, from public and private plans and payers, regardless of whether their populations are participating, will be encouraged to participate in the design and development processes. The Division is committed to aligning models with other CMS initiatives to the extent that it does not limit innovation or collaboration efforts among payers and populations.

The Division is evaluating the impact of the 2014 Patient Protection and Affordable Care Act (PPACA) Medicaid expansion on programs and services and is working with state and local government health care officials to determine if services to indigent Nevadans will be payable through Medicaid.

Part 4. Leveraging Regulatory Authority

DHCFP is committed to using its full range of regulatory, policy, and rule making authority to influence the structure and performance of the State's health care system. It is our intention that all options are open for consideration providing congruency with the State's overall health

objectives, Governor Sandoval's health care priorities, and the guiding principles described under Part 2. Nevada is prepared to propose and/or support changes in statutory authority at the state and/or federal level under the same conditions. These regulatory authorities include:

- Aligning processes and criteria.
- Reinforcing delivery system transformation or developing alternative approaches.
- Developing regulatory approaches to improve the effectiveness, efficiency, and appropriate mix of the health care work force.
- Creating opportunities to align state regulations and requirements for health insurers with the broader goals of multi-payer delivery system and payment reform.
- Integrating value-based principles.
- Evaluating the contracting processes that provide the most competitive combination of value, quality, and choice.
- Increasing medical, paramedical, practitioner, dental, and pharmacist education.
- Involving other regulatory authorities that support delivery system transformation.

Part 5. Health Information Technology

Health information technology and data analytics are important to achieving goals and objectives throughout this initiative. Nevada is committed to a robust statewide collaborative process to design and develop an innovative health care delivery system that optimizes efficiency and improved outcomes. DHCFP is committed to developing strategies that complement, and do not supplant other funding sources, and we are committed to the continued use and refinement of models sustained after the cooperative agreement period has ended.

The Division will assess the availability and reliability of data needed using HealtHIE,

which is a not-for-profit statewide community-based health information exchange (HIE). This initiative will capitalize on the Division's electronic health record (EHR) program that went "live" on August 6, 2012. It includes incentive payments for Eligible Professionals (EP), Eligible Hospitals (EH), and critical access hospitals (CAH) for Adopt/Implement/Upgrade (AIU) and Meaningful Use (MU). As of June 10, 2014, the Nevada DHCFP reported payments to 340 providers and 27 hospitals, with incentive payments totaling more than $34 million.

The State's executive leadership team will direct the planning and oversight of design and development activities and utilize policy and regulatory levers to accelerate standards based health information technology adoption to facilitate improvement in delivery system care. Effective communication, planning and project management will be used for promoting patient engagement and shared-decision making; and for developing multi-payer strategies to enable and expand the use of health information technology to make data driven decisions to coordinate and improve care across the state. Workgroups and committees will be tasked with studying and developing plans to utilize telehealth to increase access and improve timeliness of care. DHCFP will provide on-going technical assistance to providers, identifying targeted provider groups that will receive assistance by using current approaches of communication such as a toll-free telephone line, banner messages, web-based training, and specialized events. DHCFP will use data analytics and health information technology to support delivery system transformation.

Part 6 - Stakeholder Engagement

A critical determinant of success for SIM is the input and on-going involvement of a broad range of stakeholders across the state. Many stakeholders are on the front lines every day,

working directly with patients, policies and procedures, as well as the barriers, restrictions, and limitations that impose upon the provider and patient relationship. The institutional knowledge gained from stakeholder experience and expertise is an invaluable resource to this initiative. DHCFP shares CMS' belief that true innovation is derived from broad stakeholder input and collaboration. Nevada will engage stakeholders about their observations on what works, what does not work, what are the risks, and what are the cost drivers or barriers that lead to inefficiencies in care delivery, poor quality outcomes, and costs that annually increase faster than inflation.

DHCFP is committed to working with a broad group of stakeholders, representative of Nevada's entire population. We will seek to collaborate with all health care providers/systems, commercial payers, state hospital and medical associations, long term services support providers, tribal communities, and consumer advocacy organizations. Each group will have an opportunity to provide input into the model design and development process, including participation in work groups and committees. Nevada plans to conduct regional collaboration sessions in both face-to-face and technology-based formats. DHCFP is committed to designing a state health plan that includes multi-payer payment innovation and measure alignment.

As a kickoff to this process, DHCFP hosted two stakeholder meetings on July 2, 2014 at 2:00 p.m. and July 8, 2014 at 8:30 a.m. Invitations were sent to stakeholders across the state including state and local government agencies, providers, local health officials, community-based organizations, health policy experts, provider industry associations, medical schools, and consumer advocacy groups, among others, allowing an opportunity for stakeholders to actively engage with the Division regarding their perspectives on the directions DHCFP should take on this SIM opportunity. This outreach afforded Nevada the opportunity to convey the importance

of their on-going support and participation in the design process.

There is a diverse range of public and private stakeholders involved in Nevada's SIM application process, including those that have provided letters of support, and those we intend to engage as we move forward. DHCFP has received broad and overwhelming support from providers and consumer groups, which is further evidenced by the large number of support letters received.

During the planning process and beyond, robust stakeholder engagement that is open and inclusive of all stakeholders is essential for ensuring the success of the project. To date, Nevada has received input from hospitals, providers, non-profits, managed care organizations, legislators, private providers, state, county, and local agencies, to name a few. Opinions and suggestions from those involved will have meaningful impact on policy and program development.

Nevada is committed to meaningful involvement of consumers and other stakeholders, which will result in a better product. Stakeholder input and active participation is critical to the success of the project and is the primary means of ensuring positive outcomes. Regular meetings will be held and workgroups will be formed with stakeholders to accomplish the goals and objectives of the SIM grant. Workgroups and committees will develop reports and communications that will be disseminated statewide. A statewide communication strategy will be developed and implemented as part of the overall plan to ensure involvement from all stakeholders.

Part 7 - Quality Measure Alignment

A key component of this initiative will be to disseminate and compare information across payers, states and programs to ensure quality measure alignment. CMS and the State have an

active interest in improving population health through a transformed health care delivery system. In order to accomplish that objective, we will assess the baseline and then establish improvement targets and goals. Providers must be able to understand how their contributions impact overall population health, particularly within their own community. Using nationally recognized standardized measures that align with other programs is central to accomplishing the objective. DHCFP has begun stakeholder presentations to establish an active dialogue prior to the submission of this grant application. Nevada will identify appropriate measures for population health, and establish consistent and reliable data for measures. This will require identifying, collecting, programming, and maintaining data needed for measures. This will be challenging as we collaborate with other payers, as each one will have certain unique features either about their service delivery and/or the way they adjudicate claims and maintain data.

Nevada recognizes many measures may require data extraction from multiple sources including utilization data, medical charts, and electronic health records. A plan will be developed to engage stakeholders to obtain data such as vital records, workforce development, and behavioral/mental health records. Upon finalizing the populations, we will aggressively pursue an assessment of data availability for all of the involved payers. DHCFP will identify the basic data needs (which will be finalized as we design the innovation pilots), the system and/or location of the information, a timeline for harvesting data, and the identification of risks to these processes and timeline. Nevada looks forward to working with CMS and other stakeholders on this critical component. Many Nevada stakeholders understand the need for measure alignment and the degree of difficulty in measure computation. Despite this challenge, Nevada is prepared to develop a statewide plan to align quality measures across all payers in Nevada. It is also an important goal that HIT and HIE is utilized as the hub of this process to minimize administrative

and/or non-clinical burden to providers in the state in terms of preparation and oversight.

Part 8 - Monitoring and Evaluation Plan

DHCFP will contribute quantifiable measures for regularly monitoring the impact of Nevada's proposed SIM model. The monitoring protocol will include an assessment of the effectiveness to-date of the policy and regulatory levers applied under the design phase, on achieving CMS' TripleAIMs of (1) strengthening population health; (2) transforming the health care delivery system; and (3) decreasing per capita health care spending. DHCFP will work with CMS to identify measures for the pilots with a focus on state population health demographics and interventions that could have a meaningful impact on Nevada's overall health and wellness. We understand that all quality and cost measures will use the state's entire population in the denominator, aligned with other approaches (e.g., Pioneer) used by Medicare. DHCFP will work closely with CMS to identify the required population measures. Nevada anticipates refining and finalizing measures in conjunction with CMS during the design and development period.

DHCFP will be responsible for monitoring and reporting to CMS on the progress and impact of the model design at regular intervals. Communication is essential to the success of the initiative and Nevada remains committed to coordinating and collaborating both with CMS and our project stakeholders. DHCFP acknowledges that CMS will conduct an independent evaluation of funded proposals in accordance with the requirements set forth in Section 1115A of the Social Security Act (added by Section 3021 of the Affordable Care Act). Nevada will be prepared to provide assistance and supply the information needed to support that effort.

Part 9 - Alignment with State and Federal Innovation

As a component of the DHCFP's management and monitoring functions, Nevada will align the SIM with all other state and federal innovations and opportunities. The Division utilizes

an effective communication and coordination strategy to ensure that Division leaders and other key personnel communicate on a routine basis. To facilitate this process, DHCFP will develop and implement a Quality Registry, a single point of entry system that will be housed on a SharePoint site within the State. All new and current quality improvement initiatives will be required to be entered into the registry. The DHCFP management team will analyze reports to identify any potential overlaps or duplication of funding. DHCFP's Grants Management Unit will continue to monitor all grant requirements and will immediately notify the project management team should any potential overlap be identified. DHCFP will ensure that the SIM will not be used for duplicative activities, or to supplant current federal or state funding. All SIM models will be developed to complement current initiatives based on the statewide goals and priorities established by Governor Sandoval.

The Division has completed an environmental scan of current initiatives that include the following: DHCFP currently has 11 initiatives and grants related to quality improvement; DPBH has 58 initiatives, grants, projects and programs; The Governor's Behavioral Health Strategic Initiatives Council is reviewing initiatives on community capacity for mental health services, crisis prevention, adequate hospital beds, stable housing, and workforce development; a multitude of other statewide health related initiatives such as broadband infrastructure capacity, peer support specialist program, and improvement to treatment plan compliance documentation. Nevada recognizes there are many initiatives ongoing statewide and will have dedicated resources to proactively monitor and align them in coordination with the SIM grant.

II. BUDGET NARRATIVE

A. Personnel (Salaries and Wages)

Personnel Total ***$ 260,193***

Position	Name	Level of Effort (FTE)	Annual Salary	Total
1. Rates Unit (RU), Chief	Jan Prentice	0.15 FTE	$ 81,140	$ 12,171
2. Mgmt Analyst (MA) IV	Tiffany Lewis	0.50 FTE	$ 54,204	$ 27,102
3. Mgmt Analyst (MA) III	Debra Sisco & To Be Hired	2.00 FTE	$ 54,595	$ 109,190
4. Admin Assistant (AA)II	Keturah Stanford	0.25 FTE	$ 30,192	$ 7,548
5. Comm. Outreach(CO-MAIII)	To Be Hired	1.00 FTE	$ 49,694	$ 49,694
6. Data Collection (PrgmOff)	To Be Hired	1.00 FTE	$ 39,000	$ 39,000
7. Project Director	Gloria Macdonald	0.25 FTE	$ 61,951	$ 15,488
Total:				**$ 260,193**

JUSTIFICATION (Base on 12-Month Program)

1. RU Chief (.15 FTE) – To provide high-level quality oversight of activities.
2. MA IV (.50 FTE) – To provide administrative and design coordination guidance; part of the core model design team; coordinate legislative and policy level decisions.
3. MA III (two at 1.0 FTE) – Assistant Project Manager and the Grants Management Manager to ensure reporting, and grant management functions and activities related to day- to-day activities. Duties will be divided into working with internal and contractual staff; facilitating daily activities; coordinating with stakeholders and contract staff; team supervision. Assistant Project Manager will manage the procurement of required consulting; oversee contract negotiation and finalization; monitor contract performance and adherence to Planning Team priorities; ensuring financial and program integrity and transparency.
4. AA II (.25 FTE) – To provide administrative and communication support.
5. CO Coordinator (Not to Exceed 1.0 FTE) – Collaboration and communication throughout the state, as needed, to develop communication plans and engage stakeholders at all levels.
6. Data Collection (1.0 FTE) – Internal to State to manage, compile and organize data.

7. Project Director (.25 FTE) – State compliance of federal and state regulations and mandates; manage grant functions; ensure submittal of all fiscal and program reports in operation of the grant.

B. Fringe Benefits: ***Fringe Benefits Total $ 85,630***

Description	Rate	Wage	Fringe
Medicare	1.45%	$260,193	$ 3,773
Workers Comp	2.88%	$260,193	$ 7,494
Health Insurance	2.70%	$260,193	$ 7,025
PERS	25.75%	$260,193	$ 67,000
Unemployment Compensation	0.13%	$260,193	$ 338
Total:			**$ 85,630**

JUSTIFICATION: Fringe reflects the current rate for Medicare, Workers Compensation, Health Insurance, Public Employees Retirement System and Unemployment Compensation.

C. **Consultant Contractual Costs:** ***Consultant Total $1,882,366***

Name/Entity	Service	Total
Myers and Stauffer, LC (MSLC)	Professional accounting, consulting, data management and analysis services. (Travel not to exceed $45,000 – comply with Fly-America; General Service Administration Rates; and Nevada travel requirements as per State Administrative Manual (SAM)	$1,882,366
Total:		**$1,882,366**

1. Name of Consultant: Myers and Stauffer LC
2. Organizational Affiliation: N/A
3. Nature of Services to be Rendered: MSLC to manage the Model Design process utilizing academic, financial, policy and clinical expertise to evaluate the state's current models of care and payment and impact of the new state model initiatives. Task 1: Project Management and Planning Assistance (regular status reports); Task 2: Research and Analysis of Project Design Options (report); Task 3: Strategy and Stakeholder Sessions

(report); Task 4: Preparation of Pilot Options for Considerations (report of options and justification); Task 5: Design and Development of Pilot Protocols (protocols and supporting documentation); Task 6: Prepare Impact Analyses (patients, programs, cost reductions, return on investment – report & project evaluation); Task 7: Identify Quality Measures Components or Models (report on alignment); Task 8: Identify Data and Health Information Technology Utilization Plan (report on HIT utilizations with recommendations); Task 9: Conduct Assessment of Model Alignment (review state federal initiatives); Task 10: Conduct Assessment of Risk Areas (report including patient care and fraud, waste and abuse); Task 11: Assist with the Development of an Evaluation Plan with DHCFP (specific plan with recommendations); Task 12: Prepare Reporting Templates, Management, Monitoring and Project Dashboard (prepare deliverables); Task 13: Prepare Communication and Coordination Plan (report with outreach criteria).

4. Relevance of Service to the Project: MSLC will bring the skills of institutional knowledge (current consultant in Nevada) with national experience working on state quality initiatives such as pay for performance and delivery system incentive payments to work with CMS and DHCFP to develop innovative models and cost savings designs. The consultant services will utilize their broad-based knowledge of health care systems and established technology and coordinated resources to research and develop the Design Model, providing an expeditious and cost effective start-up by the State of Nevada.
5. Number of Days of Consultation: The total number of hours for consultant activities will not exceed 8,192 which includes experts from MSLC at all levels and additional support as the project demands. This project is under 195 days of consultation.

6. Expected Rate of Compensation: Consultant, inclusive, will not exceed 8,192 hours to provide services to the DHCFP on this Model Design Project with an average rate of compensation of $219.57. Direct expenses related to travel: All travel will be subject to the DHCFP travel policy per the Nevada State Administrative Manual and the GSA.
7. Justification of expected rates: Consultant has proposed rates and a budget that are based on their experience with other similar opportunities and project requirements. The rates are based on MSLC's approved schedule. No other indirect costs are requested.
8. Method of Accountability: The DHCFP will work to monitor performance and confirm work is delivered timely and within budget. All payments are subject to DHCFP's authorization based on the Consultant's performance and achievements. MSLC utilizes a time management system to record all employee time. Time is coded by project in 15-minute increments. MSLC has internal and external processes to confirm compliance.

D. Travel and Training: ***Travel (in-State and out-of-State)*** ***Total*** ***$ 14,678***

Purpose	Location	Item	Rate	Total
1. Attend orientation & close out meetings at CMS (if required by CMS)	Washington, D.C. area	Airfare	$750 flight/ 2 ppl / 2xs	$ 3,000
		Hotel	$224 per night /2 nights / 2 ppl	$ 896
		Per-Diem	$71 per day/3 days/ 2 ppl	$ 426
		Trans-portation	Cab $60; Airport Parking $15; Travel to/from airport $14/RT for 2 ppl/ 2 trips	$ 356
			Sub Total: Out-of-State Travel	$ 4,678
2. Local travel for DHCFP staff	Throughout Nevada	Travel through Northern and Southern Nevada as well as the rural communities		$10,000
			Sub Total: In-State Travel	$10,000
Grand Total Travel:				**$14,678**

JUSTIFICATION: 1) The key staff to attend grantee orientation and close out conferences, if required; 2) Quarterly Travel through Northern and Southern Nevada by key staff members.

E. Other (Itemized): ***Other Total $75,600***

Service (Not to Exceed Amounts)	Total
1. Office Supplies; $300/month X 12 month program	$ 3,600
2. Stakeholder expenses for outreach; Telephone, mail, printed materials, meeting rooms.	$ 12,000
3. Outside Evaluation from University of Nevada, Reno	$ 60,000
Total:	**$ 75,600**

F. Indirect Costs: ***Indirect Cost Total: $231,847***

Direct Costs: $2,318,467	**Total Indirect: $231,847** **Fringe 10%**

JUSTIFICATION: The rate is 10% and is computed based off of all direct costs.

G. Total Funding Requested ***$2,550,314***

H. Total other Revenue or In-Kind Support ***In-Kind: $ 150,000***

In-Kind Support	Amount:
Clark County Social Services (outreach; program support; coordination)	
Division of Public and Behavioral Health (evaluation; health measures; outreach and coordination)	
Silver State Health Insurance Exchange (coordination; data)	
Governor's Council on Behavior and Wellness (outreach and coordination; technical support)	
State of Nevada Grant Office (compliance, communication outreach and development; grant)	
Total:	**$ 150,000**

I. EQUIPMENT: **NONE**

J. ATTESTATION: The State of Nevada attests that any funds for the Nevada State Innovation Model Design will not supplant or duplicate funds from other sources.

III. FINANCIAL ANALYSIS

Initially the model design will focus on five different sets of Nevada residents and will include individuals covered by CHIP, Medicaid, IHS, PEBP, and the Culinary Union. The five different reimbursement models cover almost 700,000 individuals out of approximately 2,800,000 residents of Nevada, so almost one in every four Nevadans will be included under initial model design.

Medicaid is by far the largest program under the design with over 500,000 beneficiaries and over $2 billion in total cost per year. The next largest group is the Culinary Union which covers approximately 120,000 individuals in Clark County. Since the Culinary Union is a private enterprise, the total cost and PMPM cost for the Culinary Union is not available. The other large group is the Nevada Public Employees Benefit Plan with over 33,000 members, where their total cost of care exceeds $110 million per year.

Based on the available data, Per Member Per Month (PMPM cost) estimates range from $630 per month for PEBP employees, $374 per month for Medicaid, and $143 per month for CHIP.

It is estimated that including the 120,000 Culinary Union members, the total cost of the five plans would be in excess of $2.1 billion a year. At this point estimating a total savings is very difficult, but if an implemented model design saved only one percent, that would equate to approximately $21.8 million in savings per year. The following table shows a breakdown of major statistics and potential savings per program at one percent and two percent.

	SFY 2014	SFY 2014	SFY 2014			
	CHIP	Medicaid	IHS	PEBP	Culinary Union	Total
Populations Being Initially Considered:						
Population	21,488	520,836	4,793	33,664	120,000	700,781
Total Cost	$37,963,456	$2,020,479,449	$13,406,760	$110,800,000	N/A	$2,152,649,715
PMPM	$143	$374	$233	$630	N/A	$1,380
Anticipated Cost Savings:						
Two Percent	$759,269	$40,409,589	$268,135	$2,216,000	N/A	$43,652,993
One Percent	$379,634	$20,204,794	$134,067	$1,108,000	N/A	$21,826,495

Medicaid Total Costs include DSH and Supplemental payments.

Notes and observed cost trends:

- PMPM - Per Member Per Month cost, estimated by assuming population is consistent throughout the year, thus formula ((Total Cost)/(Population *12)), unless other PMPM statistics is quoted
- CHIP expenditures from DHCFP for SFY 2014
- Medicaid Population from DHCFP for SFY 2014
- Medicaid Total cost from DHCFP for SFY 2014
- IHS information from DHCFP for SFY 2014
- Culinary Union has 120,000 participants in Las Vegas Area, per the CulinaryHealthfund.org
- PEBP includes a self-funded Preferred Provider Organization (PPO) plan as well as a Health Savings Account. Most recent information is from fiscal year 2013 (month end June 2013) and represents benefit cost only (i.e., capitation amounts excluded). PMPM between 2012 and 2013 was up only 0.1%, medical claims, experienced decrease while both dental and pharmacy trended upward. http://pebp.state.nv.us/fiscal/Utilization_Report_FY13_Q4.pdf

IV. OPERATIONAL PLAN

Nevada's operational plan describes the activities and budgets for the performance period of the award and includes a detailed time line for the design process with dates and major milestones, roles and responsibilities of key partners and payer participants, and key personnel, including their backgrounds, respective roles and overall responsibilities. It also addresses the Governor's existing and future involvement in the model's design and implementation and the involvement of other state agencies that will be actively involved in designing the model. Lastly, it addresses assumptions made and risks to the operational timeline, and projected strategies for mitigating identified risks.

Timeline and Major Milestones

Activity	Expected Completion Date	Deliverables
Grant Submission to CMS	July 21, 2014	
CMS Award Funding	October 31,2014	
Internal Kickoff Meeting (Core Team)	January 6, 2015	
Internal Kickoff Meeting (Internal State Stakeholders)	January 8, 2015	Receive preliminary model design outline
Update Project Plans and Timelines	January 12, 2015	
Kickoff Meeting with CMS Innovations Center	January 16, 2015	Discuss model design outline with CMS
Develop Communication and Coordination Plan	January 30, 2015	Prepare Communications Plan
Identify Opportunities to Attend On-site Q&A sessions with Round 1 States	January 30, 2015	Potential modifications of model design outline
Design/Develop a Monitoring and Evaluation Plan	February 13, 2015	Evaluation Plan
Schedule and Attend Stakeholder Meetings (Internal and External)	February 13, 2015	Solicit input from stakeholders
Identify and Schedule Individual Meetings with Large Provider Systems or Other Providers	February 27, 2015	Solicit input from providers regarding model design
Formulate Work Groups and Committees	February 27, 2015	Prioritize input received
Prepare Data and Information Requests for various stakeholders	March 13, 2015	Request Data
Initial Research and Analysis of Project Design Options	March 25, 2015	Research options
Hold Follow-up Strategy and Stakeholder Sessions (Internal and External)	April 7, 2015	Present model design status
Preparation of Pilot Options for Consideration	May 8, 2015	Present refined Options
Design and Development of Pilot Protocols	May 20, 2015	Develop Protocols and Measurement tools

Activity	Expected Completion Date	Deliverables
Hold Follow-up Strategy and Stakeholder Sessions (Internal and External)	May 28, 2015	Present current Status to stakeholders
Prepare Impact Analyses	June 5, 2015	Impact Analyses
Prepare Status Reports and Regular Updates for core groups and stakeholders	Monthly	Impact Analyses
Identify Quality Measurements	June 15, 2015	Impact Analyses
Identify Data and Health Information Utilization Plan	June 15, 2015	Impact Analyses
Hold Follow-up Strategy and Stakeholder Sessions (Internal and External)	July 9, 2015	Present current status to stakeholders
Conduct Assessment of Model Alignment with other State/Federal Initiatives	July 10, 2015	Impact Analyses
Conduct Assessment of Risk Areas	July 24, 2015	Impact Analyses
Monitor/Update on Evaluation Plan	September 14, 2015	Evaluation plan status
Participate in Stakeholder Presentations (Internal and External)	September 14 – 18, 2015	Present Model Design
Prepare Reporting Templates, Management Monitoring and Project Dashboard	October 5, 2015	Build Reporting Templates
Receive and Update Reports Based on Comments	November 13, 2015	Report Revisions
Finalize Reports	November 20, 2015	Recommendations Completed
Participate in Final Presentations and develop timeline for Test Design	November 24, 2015	Project Roll-out

Itemized Expenditure Plan

ITEM	COST
Personnel Costs	$260,193
Fringe Benefit Costs	$85,630
Contractor/Consultant Costs	$1,882,366
Travel and Training	$14,678
Other:	
Office Supplies	$3,600
Stakeholder Expenses for Outreach	$12,000
Outside Evaluation from Univ. of Nevada, Reno	$60,000
Sub-Total Direct	**$2,318,467**
Indirect/Overhead Costs (10%)	$231,847
Total Funding Request	**$2,550,314**
In-Kind Support	$150,000
Equipment	$0

Attestation: The State of Nevada attests that any funds for the Nevada State Innovation Model Design will not supplant or duplicate funds from other sources.

Key Partners and Payer Participants: Nevada will partner with Myers and Stauffer LC (MSLC), a certified public accounting and consulting firm. MSLC will manage the Model Design process utilizing academic, financial, policy and clinical expertise to evaluate the state's current models of care and payment and impact of the new state model initiatives. Jared Duzan will serve as the Lead from MSLC.

Key Personnel and Experience

Janice Prentice: Janice Prentice is the Chief of the Rates and Cost Containment Unit of DHCFP and has been a State of Nevada employee for more than 15 years. She currently oversees staff in the development of reimbursement rates, provider cost analysis, supplemental payment programs, cost containment, provider tax program, contract management, State Plan amendments, and regulation changes. She has 13 years of experience as a Medical Claims Examiner in the private and public sector and four years of experience as a quality assurance manager, managing a medical claims audit process for seven states. Jan holds certifications in State Contract Management, Supervisory Management and Project Management. She will have management oversight of this project.

Gloria Macdonald, CPA: Gloria is the Chief of the Medicaid Grants Management Unit of DHCFP since the spring of 2012. Gloria oversees the federal grant process. She also oversees the Quality Assurance Unit, which collaborates with state agencies to develop, operate and sustain quality improvement within the 1915c Home and Community Based Services Waiver Programs. As a certified public accountant, she has worked in public accounting and private industry including construction, proper management and financial management, state government and tribal government environments. She will remain the grants manager of this project.

Tiffany M. Lewis: Tiffany is the rates supervisor for the Rates and Cost Containment Unit for more than two years and a State of Nevada employee for more than six years. She oversees staff in the development of reimbursement rates for over 60 provider types, State Plan amendments and Medicaid services manual updates, provider rate negotiations, provider appeals, project management and federal compliance. Tiffany has 20 years of administrative and patient health care experience in the private and public sector including practice management, commercial insurance and Medicaid fee for service provider reimbursement rate development, contract negotiations, provider relations and patient care. Tiffany holds a certification in State Contract Management with the State of Nevada and is currently pursuing the Certified Public Managers designation. She will be a Subject Matter Expert for this project.

Rebecca Vernon-Ritter: Rebecca began working for the DHCFP in March 2013. Her prior experience includes 20 years with the Division of Mental Health and Developmental Services, working in various positions related to program and fiscal analysis, and provided grant oversight for the Division. She was responsible for coordination and preparation of federal grant applications. She held a State Contract Management certificate and was the Agency's Certified Contract Manager. She was responsible to know federal compliance requirements for all funding received. She will be a Subject Matter Expert for this project.

Debra L. Sisco: Debra is a management analyst in the Rates and Cost Containment Unit of DHCFP. She oversees the calculation and administration of Inpatient and Outpatient (UPL) and GME supplemental payment programs to eligible hospitals while maintaining compliance with CMS, NRS, NAC and Nevada State Medicaid Plan. She is responsible for calculating and reporting the UPL's for all provider types as required by CMS as required by SMDL 13-003. In addition, she is the lead analyst responsible for the preparation of the annual publication to the Governor and Nevada Legislature on the status of hospitals in Nevada. Debra holds a certification in State Contract Management and manages all contracts for Rates and Cost Containment Unit. She will be the Project Manager for this project.

Jared Duzan: Jared is a principal (partner) with Myers and Stauffer LC. He oversees the firm's benefit/program integrity practice area, including consulting for health care innovation pilots with the CMS Innovations Center, managed care auditing, fraud and abuse detection, recovery audit contractor, quality improvement and loss prevention initiatives, claims analysis, compliance audits, Medicaid Management Information System (MMIS) adjudication audits, and payment error rate measurement (PERM) studies.

Mr. Duzan has direct delivery system reform and transformation experience, having directed the development and implementation of the New Jersey DSRIP program. He has more than 17 years of experience in public health policy, research, data analysis, utilization management, reimbursement and Medicaid policy consulting. Mr. Duzan is experienced with a multitude of health care provider categories and both fee-for-service and managed care delivery systems.

Governor's Involvement: The Governor, and/or his designee, will have final approval of the design and policy features of this initiative. He has instructed the team to utilize his strategic priorities as the foundation for any health care/quality improvement initiatives. Nevada has identified seven objectives for health priorities.

Assumptions and Risks: In designing a model, it will be critical to have accurate, complete and up-to-date data. Multiple sources will be used to obtain the data and the data will be analyzed to determine its accuracy and completeness. In addition, despite a willingness of some providers and payers to participate, they may not have the technical capability to extract the needed data or it is possible they have not historically captured all of the data elements.

There is a risk that not all stakeholders will agree on the model design. We plan to mitigate this risk by having early, effective, and on-going communications with all stakeholders. All input will be received and weighed before making final decisions.

Many providers and payers have internal quality initiatives and understand the need to develop new state-wide initiatives that must be able to be measured consistently. However, stakeholders may have different visions of what constitutes success and individual visions may also be in conflict between stakeholders. Nevada is prepared to develop a statewide plan to align quality measures across all stakeholders as part of this initiative, and frequently report on the measures to ensure buy-in from all stakeholders.